FORGED IN THE FIRE

Human Trafficking Screening Toolkit

Identifying Trafficking in Healthcare and Social Service Settings

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Human Trafficking Screening: A Trauma-Informed Toolkit for Identification, Response, and System Implementation

Forged in the Fire — Knowledge Base Research Paper

Executive Summary

Screening is the practice of routinely and systematically asking questions designed to identify people who may be experiencing or have experienced human trafficking, in order to offer support and connection rather than to investigate, label, or report (HEAL Trafficking, 2022; HHS Office on Trafficking in Persons [OTIP], 2018). Federal agencies, validated research instruments, and survivor-led organizations agree that effective screening is universal in high-risk settings, trauma-informed in approach, relational rather than interrogative, and structurally connected to immediate, voluntary support pathways (Vera Institute of Justice, 2014; HHS, 2018; HEAL Trafficking, 2022). The two most widely used validated U.S. instruments are the Adult Human Trafficking Screening Tool (AHTST), developed by HHS/OTIP, and the Trafficking Victim Identification Tool (TVIT), developed by the Vera Institute of Justice. For child and adolescent settings, screening tools developed by Greenbaum and colleagues and the Commercial Sexual Exploitation–Identification Tool (CSE-IT) by WestCoast Children's Clinic are commonly used. Screening, however, is never adequate alone: it must be embedded within an organizational protocol that includes private screening conditions, language access, mandatory reporting clarity, immediate warm referrals to advocates, and quality-assurance practices. This paper provides the research foundation, legal context, ethical framework, and practical implementation guidance for screening across nonprofit, healthcare, educational, and community settings.

I. Introduction

Human trafficking is significantly under-identified in the United States. Survivors often interact with healthcare, social service, child welfare, school, faith, and criminal-legal systems while being trafficked, but are rarely identified as victims at the point of contact (Lederer & Wetzel, 2014; Polaris Project, 2018). Studies in emergency departments and other healthcare settings have found that the majority of trafficking survivors had at least one healthcare encounter during their trafficking, but were not identified as victims at the time (Lederer & Wetzel, 2014; Chisolm-Straker et al., 2016). Screening — conducted thoughtfully and within a trauma-informed protocol — is one of the few evidence-supported strategies for closing that identification gap (HEAL Trafficking, 2022; HHS, 2018).

This paper is intended for nonprofit leaders, direct service staff, healthcare partners, educators, shelter and housing programs, and community organizations considering or already implementing screening. It synthesizes federal frameworks, peer-reviewed research, validated instruments, and survivor-led practice, and concludes with implementation recommendations for Forged in the Fire and partners.

II. Definitions and Scope

Screening in this context refers to a brief, standardized inquiry designed to identify the possibility of trafficking and to offer support — not to render a clinical or legal determination of trafficking victim status, which is a function of advocates, investigators, and adjudicators (HHS, 2018; Vera Institute of

Justice, 2014). Screening is distinct from assessment, which is more in-depth and typically conducted after disclosure or screening positive, often by a trained advocate or clinician. It is also distinct from investigation, which is a law enforcement or regulatory function.

Universal screening refers to asking the same screening questions of all individuals served in a given setting, rather than only those who fit a perceived risk profile, in order to reduce bias and increase identification (Greenbaum et al., 2018; HEAL Trafficking, 2022). Targeted screening refers to focused screening of populations with known elevated risk, such as runaway and homeless youth, child welfare-involved youth, certain emergency department presentations, or labor populations in industries with documented trafficking concentration (HHS, 2018; Polaris Project, 2018).

The scope of this paper covers screening for both sex trafficking (the recruitment, harboring, transportation, provision, obtaining, patronizing, or soliciting of a person for the purpose of a commercial sex act induced by force, fraud, or coercion, or in which the person induced to perform such act has not attained 18 years of age) and labor trafficking (the recruitment, harboring, transportation, provision, or obtaining of a person for labor or services, through the use of force, fraud, or coercion for the purpose of subjection to involuntary servitude, peonage, debt bondage, or slavery), as defined under the federal Trafficking Victims Protection Act, 22 U.S.C. § 7102.

III. Current Research and Data

The empirical case for screening rests on several converging findings.

Healthcare contact during trafficking is common. Lederer and Wetzel (2014), in a survey of 106 sex trafficking survivors, reported that 87.8% had contact with a healthcare provider during their trafficking; the majority were not identified. Chisolm-Straker, Richardson, and Cossehl (2012) and Chisolm-Straker et al. (2016) documented similar patterns in emergency department settings. Mumma et al. (2017) demonstrated that emergency department screening protocols can detect trafficking that would otherwise be missed.

Validated instruments perform meaningfully better than clinical impression alone. The Vera Institute of Justice (Simich et al., 2014) developed and validated the Trafficking Victim Identification Tool (TVIT), demonstrating sensitivity and specificity that significantly exceeded provider judgment without a structured tool. The TVIT exists in long and short forms and addresses both sex and labor trafficking.

The Adult Human Trafficking Screening Tool (AHTST) was developed by HHS/OTIP through a multi-year process and released as a flexible federal-recommended instrument (HHS, 2018). The AHTST is designed to be adaptable to setting, length, and population, with core domains covering migration, work and living conditions, freedom of movement, debt, and threats and coercion.

For child and adolescent populations, the Commercial Sexual Exploitation–Identification Tool (CSE-IT) developed by WestCoast Children's Clinic has been validated for use in child welfare and youth-serving settings (Basson et al., 2017). Greenbaum and colleagues (2018) developed and validated a six-question screening tool for use with adolescents in healthcare settings, demonstrating high sensitivity for commercial sexual exploitation.

Screening implementation outcomes in adjacent fields (intimate partner violence, suicide, alcohol use) consistently show that universal, structured screening with embedded warm-referral pathways

outperforms clinician judgment alone (Moyer & U.S. Preventive Services Task Force, 2013), and that the most significant determinants of screening effectiveness are not the instrument chosen but the implementation infrastructure: training, private space, immediate referral pathways, and policy clarity.

What remains under-researched: optimal frequency of re-screening; comparative effectiveness across instruments; screening outcomes in faith-based and community settings; screening for labor trafficking specifically (the field is significantly behind sex trafficking screening research); and screening adapted for male, LGBTQ+, disabled, and non-English-speaking survivors (HEAL Trafficking, 2022).

IV. Legal and Policy Framework

Federal and state legal frameworks shape both the obligations and the permissions around screening.

The Trafficking Victims Protection Act, 22 U.S.C. § 7101 et seq., and its reauthorizations through the Frederick Douglass Trafficking Victims Prevention and Protection Reauthorization Act of 2018 establish the federal framework and have driven federal investment in screening tool development through HHS/OTIP, OVC, and other agencies.

The federal Strategic Action Plan on Services for Victims of Human Trafficking in the United States (HHS, DOJ, & DHS, 2014, with subsequent updates) explicitly identifies screening and identification as priority pillars and directs agencies to support validated tool development and dissemination.

The Preventing Sex Trafficking and Strengthening Families Act (Pub. L. No. 113-183, 2014) requires state child welfare agencies to identify, document, and report children and youth who are sex trafficking victims and to develop screening protocols for child welfare-involved youth.

Healthcare-specific policy includes the HHS SOAR (Stop, Observe, Ask, Respond) to Health and Wellness training (HHS, 2022) and ICD-10-CM diagnosis codes for human trafficking (T74.51, T74.52, T76.51, T76.52, and Z04.81/Z04.82 for suspected encounters and follow-up, effective October 2018), which support documentation and population health surveillance (American Hospital Association, 2018).

Mandatory reporting intersects directly with screening. Under California Penal Code § 11164 et seq. (the Child Abuse and Neglect Reporting Act), mandated reporters must report known or reasonably suspected child abuse, including commercial sexual exploitation of children, regardless of disclosure context. California Welfare and Institutions Code §§ 300(b)(2) and 16524 et seq. address commercially sexually exploited children specifically. Federal mandatory reporting under the Child Abuse Prevention and Treatment Act (CAPTA, 42 U.S.C. § 5106a) requires that states screen for and report suspected child abuse and trafficking. Adult survivor disclosures are not subject to mandatory reporting in California except under specific statutes (e.g., elder and dependent adult abuse, certain wound reporting under Penal Code § 11160).

Privacy law governing screening practice includes HIPAA (45 C.F.R. Parts 160, 162, and 164) for covered healthcare entities; FERPA (20 U.S.C. § 1232g) for educational settings; and California's Confidentiality of Medical Information Act (Civil Code § 56 et seq.) and California Consumer Privacy Act for additional protections. Trauma-informed screening requires that providers understand and disclose the limits of confidentiality before inviting disclosure.

Provider liability and protections. California Penal Code § 11172 provides civil and criminal immunity for mandated reporters who report in good faith. No California or federal statute imposes liability for offering trauma-informed screening or for documenting clinical concerns that do not rise to the level of a mandatory report.

For Forged in the Fire and partners, the practical implication is that screening must be designed in tandem with mandatory reporting protocols, privacy protections, and explicit informed-consent practices.

V. Risk Factors and Vulnerabilities (Screening-Relevant Considerations)

In a screening context, “risk factors and vulnerabilities” inform two practical questions: which settings warrant universal versus targeted screening, and which screening adaptations are needed for which populations.

Settings with documented elevated trafficking prevalence include emergency departments and urgent care, sexual and reproductive health clinics, runaway and homeless youth services, child welfare-involved settings, juvenile justice settings, immigration legal services, certain school settings (including schools serving foster youth and unaccompanied minors), domestic violence shelters, substance use treatment settings, and certain labor-population services such as agricultural worker health clinics (Polaris Project, 2018; Greenbaum et al., 2018; Chisolm-Straker et al., 2016).

Populations with elevated risk identified across the federal and academic literature include youth in foster care or experiencing homelessness; youth with prior sexual abuse histories; LGBTQ+ youth, particularly those experiencing family rejection; runaway youth; youth and adults with developmental, intellectual, or psychiatric disabilities; immigrant populations, including unaccompanied minors and individuals on temporary visas; Indigenous communities, particularly in regions with documented Missing and Murdered Indigenous Persons crises; and individuals in industries with documented labor trafficking concentration including domestic work, agriculture, food service, hospitality, construction, and certain salon, massage, and traveling sales industries (Polaris Project, 2018; Owens et al., 2014; HHS, 2018).

Identification of risk does not equal identification of victimhood, and screening protocols must avoid profiling. Research has documented that bias-driven targeted screening — for example, screening only Black girls or only foreign-born women — both misses survivors who do not fit the profile and produces inappropriate scrutiny (HEAL Trafficking, 2022). Universal screening within a defined setting is the recommended approach to mitigate bias.

Re-traumatization risks of screening itself include screening in the presence of the suspected trafficker or controller (a documented danger across the literature); screening without language access or with informal interpretation; screening that uses interrogative tone, jargon, or labels (e.g., asking “Are you a trafficking victim?”); screening without an immediate referral pathway; and screening that becomes documentation that the survivor cannot control or correct (HEAL Trafficking, 2022; Macy & Graham, 2012).

VI. Recruitment, Grooming, and Control Tactics (Implications for Screening)

Trafficker control tactics shape what survivors can and cannot disclose at the moment of screening, and effective screening protocols are designed around this reality.

Presence-based control. Traffickers commonly accompany survivors to appointments, claim to be family members or partners, hold identification documents, and answer questions on behalf of the survivor (Polaris Project, 2018). Effective screening protocols include separating the patient or client from any accompanying person before screening, with a documented and rehearsed practice for doing so respectfully (e.g., “We have a clinic policy that we ask all patients these questions privately”).

Fear-based suppression. Survivors may reasonably fear retaliation, immigration consequences, child welfare involvement, or criminal exposure if they disclose (Polaris Project, 2023; HEAL Trafficking, 2022). Screening protocols must therefore (a) not promise confidentiality that cannot be honored, (b) clearly explain what disclosure will and will not trigger, and (c) make support available regardless of disclosure.

Coached responses. Survivors may have been coached on what to say to authorities. The trauma-informed response is not to interrogate but to offer multiple opportunities over multiple encounters and to ensure that resources are offered regardless of screening outcome.

Identity manipulation. Many survivors do not identify as “trafficked,” “victim,” or “prostituted” — labels may be irrelevant or harmful to the survivor’s self-understanding, and may also be tied to coaching or shame (Hopper, 2017; National Survivor Network, n.d.). Screening questions therefore focus on conditions (control, freedom of movement, debt, threats, withholding of pay, withholding of documents) rather than labels.

Document control. Asking whether the person holds their own identification, whether they receive their own pay, and whether they can leave their living situation are commonly recommended structural questions across validated instruments (HHS, 2018; Vera Institute of Justice, 2014).

Trauma response patterns. Dissociation, flat affect, fragmented narrative, eye-contact avoidance, and apparent calm in the face of clear harm are all trauma responses, not credibility signals. Trauma-informed screeners do not weigh affect against narrative content (Herman, 1992; HEAL Trafficking, 2022).

VII. Survivor Impact (Why Screening Practices Matter)

Screening is itself an intervention. Done well, it can be the first time a survivor is offered respectful, voluntary, accurate information about resources. Done poorly, it can confirm prior beliefs that systems are unsafe and that disclosure is dangerous.

Survivors report that screening encounters that were experienced as supportive — even when the survivor did not disclose — sometimes prompted later help-seeking (Polaris Project, 2023; Macy & Johns, 2011). Conversely, survivors report disengagement, avoidance of future services, and reinforcement of trafficker narratives following negative screening experiences (HEAL Trafficking, 2022).

This implies a counterintuitive but essential principle: the goal of screening is not maximal disclosure rate. The goal is that every screened person — disclosing or not — leaves the encounter with accurate information about resources, an experience of being treated respectfully, and a pathway back to help on their own terms (HEAL Trafficking, 2022; HHS, 2018).

VIII. Service Needs and Intervention Models (Screening Within a Protocol)

Screening is one component of a broader identification-and-response protocol. The HEAL Trafficking Protocol Toolkit (HEAL Trafficking, 2022), the AHTST implementation guidance (HHS, 2018), and the Vera Institute's TVIT materials (Simich et al., 2014) converge on the following core elements.

Pre-screening conditions. Private setting; suspected trafficker or controller separated; accurate language interpretation by a trained, professional interpreter (never a family member, accompanying person, or untrained staff); adequate time; staff trained in the protocol; written organizational policy.

Opening framing. A neutral, normalizing introduction that explains the purpose and the universal nature of the screening. A widely used framing structure (paraphrased from HHS and HEAL guidance) is: "We ask everyone these questions because we want to make sure you have information about resources that may be helpful. You don't have to answer anything you don't want to, and your answers won't affect the care you receive today."

Structural questions. Validated instruments share a common set of domains:

Movement and freedom: Can the person come and go freely? Is anyone controlling their movement?

Living conditions: Where do they live, with whom, and can they leave?

Identification and documents: Do they hold their own ID, passport, work permit, or visa?

Work and pay: Are they working? Are they being paid? Are they receiving the pay directly?

Debt: Do they owe a debt to anyone for the work or migration arrangement? Has the debt grown?

Coercion and threats: Are they being threatened? Are family members being threatened? Are they afraid of someone?

Force and harm: Have they been physically or sexually harmed in connection with the situation?

The exact wording, length, and order are setting-specific. The AHTST and TVIT both offer modular forms; HEAL Trafficking provides healthcare-specific adaptations; Greenbaum et al. (2018) provide a six-question adolescent healthcare adaptation.

Disclosure-agnostic resource offering. All screened individuals receive information about the National Human Trafficking Hotline (1-888-373-7888 / text 233733) or relevant local advocate, regardless of disclosure. Information is offered in formats that can be safely retained (small printed cards, brief verbal mention, online access information) or memorized.

Warm handoff. When a survivor wishes to engage further, the screener connects them directly — by phone, by walking them to an in-house advocate, by scheduling a same-day appointment — rather than handing them a phone number. The literature is consistent that warm handoffs significantly outperform passive referrals across helping fields (SAMHSA, 2014).

Mandatory reporting protocol. For minors, mandated reporters comply with their reporting obligations. The trauma-informed standard requires that the reporter: disclose the reporting obligation before disclosure is invited; minimize retraumatization in the reporting process; remain involved with the youth across the reporting transition; and document only what is necessary for the report.

Documentation. Documentation should be minimized, accurate, and consistent with the survivor's safety. Use of ICD-10-CM trafficking codes (T74.51, T74.52, T76.51, T76.52) supports clinical care continuity but should be discussed with the patient where possible. Free-text documentation that includes identifying details, statements made by the patient, or third-party allegations should be approached with caution given subpoena and discovery exposure (American Hospital Association, 2018; HEAL Trafficking, 2022).

Quality improvement. Effective protocols include ongoing tracking of screening completion rates, disclosure rates, referral completion rates, staff training currency, and survivor feedback (where it can be ethically collected). Failure of screening is most often a system failure, not an individual failure, and quality improvement should be structural.

IX. Prevention and Public Awareness

Screening contributes to prevention in three distinct ways.

Secondary prevention — reducing the duration and severity of harm by identifying victimization earlier — is the most direct contribution. Universal screening in high-risk settings, paired with effective response infrastructure, shortens time-to-services for those who choose to engage (HEAL Trafficking, 2022; HHS, 2018).

Tertiary prevention — reducing the consequences and recurrence of victimization — is supported when screening connects survivors to long-duration services, including those described in the companion paper on healing resources.

System prevention — reducing the conditions under which survivors fall through the cracks — is supported when screening data are aggregated (with appropriate privacy protections) to identify systemic gaps, target staff training, and inform funding and policy decisions.

Public awareness messaging about screening should emphasize that screening is safe, voluntary, and respectful; that survivors do not need to identify as victims to receive help; and that resources are available regardless of disclosure. Public messaging must avoid implying that all survivors should be expected to disclose at first contact, which is contrary to research and survivor experience.

X. Relevance to Forged in the Fire

Screening is relevant to Forged in the Fire in several distinct capacities.

As a service capacity. If Forged in the Fire delivers direct services in settings where intake or assessment occurs, the organization should adopt a written, trauma-informed screening protocol consistent with AHTST or TVIT practices, with documented training and supervision, language access, mandatory reporting clarity, and warm-referral pathways.

As a partner. Forged in the Fire can support healthcare, school, shelter, and faith-community partners in implementing screening — through training, protocol consultation, advocate-on-call partnerships for warm referrals, and resource-card distribution. This represents a high-impact, relatively low-cost service area.

As a community educator. Public-facing materials about screening — what it is, what it is not, why it matters, and how to support someone who screens positive — strengthen the broader identification ecosystem. This content fits well on the Forged in the Fire website as a section accessible to professionals, students, and community members.

As a grant-funded program. Screening protocol implementation, training, and warm-referral infrastructure align with federal funding priorities (OVC Human Trafficking Program, OTIP, HRSA for healthcare partners, OJJDP for youth-serving partners) and California state funding (California Office of Emergency Services), strengthening grant competitiveness.

For Forged in the Fire's programming specifically, three high-leverage opportunities are particularly worth considering: (1) developing a faith-community-adapted screening and response protocol grounded in HEAL Trafficking and AHTST frameworks; (2) building an advocate-on-call partnership with healthcare and school partners for warm handoffs; and (3) producing trauma-informed training for community partners, with continuing education credit where possible.

XI. Ethical Considerations

Several ethical considerations are particularly salient in screening.

Voluntariness. Screening is offered, not imposed. The right to decline must be communicated clearly, and decline must not affect care or service eligibility (HEAL Trafficking, 2022; HHS, 2018).

Informed consent and the limits of confidentiality. Mandatory reporting and other disclosure obligations must be explained before disclosure is invited. Failing to do so violates informed consent and risks survivor safety (Hopper, 2017; HEAL Trafficking, 2022).

Avoidance of profiling. Screening practices that target individuals based on race, ethnicity, immigration status, gender, or class — rather than based on the universal practice of the setting — are unethical, ineffective, and harmful (HEAL Trafficking, 2022).

Documentation discipline. Documentation must be minimized, accurate, and respectful. Free-text documentation can be discoverable in legal proceedings against the survivor or against the trafficker, and details written by a screener may not be how the survivor would have framed their experience. The principle is to document what is clinically or legally necessary, no more (American Hospital Association, 2018; HEAL Trafficking, 2022).

Non-exploitation of screening data. Aggregated data should not be used in fundraising or awareness materials in ways that could re-identify individuals or characterize survivors in stigmatizing ways. Survivor stories that emerge from screening encounters are subject to all the consent and dignity protections discussed in companion papers (National Survivor Network, n.d.; HEAL Trafficking, 2022).

Vicarious trauma protection for screeners. Screening exposes staff to disclosure of severe trauma. Organizations have an ethical obligation to provide training, supervision, debriefing, mental health support, workload calibration, and a culture in which screeners can talk about their experience (Pearlman & Saakvitne, 1995; SAMHSA, 2014).

Cultural humility. Screening protocols must be developed and reviewed with attention to cultural, linguistic, gender, and identity diversity, and adapted as needed in partnership with affected communities (Tervalon & Murray-García, 1998).

XII. Gaps, Challenges, and Future Research

Several significant gaps inform implementation strategy.

Implementation gap. The largest gap is not the absence of validated tools but the underdeveloped infrastructure for trauma-informed implementation across settings — particularly outside of well-resourced healthcare systems and large urban areas (HEAL Trafficking, 2022; Polaris Project, 2023).

Labor trafficking screening. Validated screening for labor trafficking specifically is significantly behind sex trafficking screening, particularly in healthcare and community settings. Greater research investment is needed (Owens et al., 2014).

Cultural and identity-specific adaptations. Validated screening adaptations for male survivors, LGBTQ+ survivors, disabled survivors, Indigenous communities, and non-English-speaking populations remain underdeveloped (HEAL Trafficking, 2022).

Adolescent screening across non-healthcare settings. While CSE-IT and Greenbaum et al. (2018) tools have advanced adolescent healthcare and child welfare screening, screening implementation in school, juvenile justice, and youth services settings remains uneven.

Outcome research. Research on long-term outcomes of screened versus unscreened populations is limited; most evidence is on detection rates rather than downstream survivor outcomes.

Faith-community settings are largely absent from the screening implementation literature, despite their substantial role in U.S. anti-trafficking response. This represents both a research gap and a practice opportunity.

Funding alignment. Funding cycles often do not match the duration required to build, train, sustain, and evaluate screening infrastructure, creating chronic implementation instability (Polaris Project, 2023).

XIII. Recommendations

For Forged in the Fire and similar organizations, the following recommendations are drawn from federal frameworks, peer-reviewed research, and survivor-led practice.

Adopt or adapt a validated screening instrument (AHTST or TVIT for adults; CSE-IT or Greenbaum et al. tool for adolescents) rather than developing a bespoke instrument, and document the choice and adaptation rationale.

Build screening into a written organizational protocol, not into individual practitioner discretion. The protocol should specify pre-screening conditions, opening framing, questions, mandatory reporting practice, documentation, and warm-referral pathways.

Train staff comprehensively, including the HHS SOAR training for healthcare partners, the OTIP Look Beneath the Surface training, and trauma-informed care foundations. Train new staff before any survivor contact and provide annual refreshers.

Resource the warm-referral infrastructure. A screening tool without a same-day, warm-referral pathway is incomplete. This means an advocate-on-call relationship, in-house advocate availability, or formal partnership with a 24/7 trafficking-specialized service.

Establish language access and cultural humility infrastructure, including trained professional interpretation (not family or staff), translated materials, and cultural review of screening practices.

Document discipline. Write organizational documentation policies that minimize unnecessary detail, leverage ICD-10 trafficking codes appropriately for healthcare partners, and protect survivor privacy.

Implement continuous quality improvement, tracking screening completion, decline, disclosure, and warm-referral completion rates as system metrics. Review with survivor advisors at least annually.

For partners and policymakers, advocate for sustained funding for screening implementation; mandatory and trauma-informed screening training for healthcare, school, child welfare, and juvenile justice settings; and statutory clarity around documentation, mandatory reporting, and confidentiality.

XIV. Conclusion

Effective screening is one of the highest-leverage practices in anti-trafficking response. It is also one of the easiest to implement poorly. The difference is structural: trauma-informed screening within a well-resourced protocol — with private space, language access, clear mandatory reporting practice, and immediate warm referral — closes the identification gap and treats the encounter as the intervention it is. Screening that exists only as a checklist on a form, without infrastructure or training behind it, is at best ineffective and at worst harmful. For Forged in the Fire, the strategic opportunity is to invest deliberately in screening as a system — adopting validated tools, training staff and partners, building referral pathways, and treating every screening encounter as a chance to communicate to one more survivor that respectful, voluntary support exists when they choose to access it.

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Self-Audit Note (per project quality control rules): Federal (HHS/OTIP, OVC, State Department, AHA coding) and peer-reviewed academic sources are prioritized, with established nonprofit (Polaris, HEAL Trafficking, Vera Institute, WestCoast Children's Clinic) and survivor-led (National Survivor Network) sources supplementing them. All major claims are tied to citations. Statistical claims (e.g., healthcare contact prevalence) are framed cautiously and tied to specific studies. Legal claims are tied to specific federal and California statutes and federal rules. Language is trauma-informed and avoids sensationalism, profiling, and rescue framing. Limitations in the evidence base — particularly around labor trafficking, cultural adaptation, and faith-community settings — are explicitly named in Section XII. Specific publication dates, statutory section numbers, and ICD-10 code listings should be verified against current versions before external publication, grant submission, training use, or partner protocol adoption.